

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14795
Registrar's No. 141-6

FILED MAY 8 1944 141

Registration District No. 141

Primary Registration District No. 5552

1. PLACE OF DEATH:

(a) County Howell
(b) City or town HOCOMO, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 months (Specify whether years, months or days)
In this community 9 months

3. (a) PRINT FULL NAME Rachel A. Mathews,

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex F 5. Color or race HW 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife I. A. Mathews, 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 3-28-1850
(Month) (Day) (Year)

8. AGE: Years 93 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Elijah Wilson, 13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Harris

15. Birthplace unk
(City, town, or county) (State or foreign country)

16. (a) Informant W. M. Martin,

(b) Address Hocomo, Missouri

17. (a) R (b) Date thereof 3-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baptist Hill

18. (a) Signature of funeral director Robertsons

(b) Address West Plains, Missouri

19. (a) 4-1-44 (b) Elijah Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town WHSCOMO
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 9th
year 1944 hour 5 minute 45a. M.

21. I hereby certify that I attended the deceased from March 1
1944 to March 9 1944

that I last saw her alive on March 5 1944

and that death occurred on the date and hour stated above

Immediate cause of death Flu, & Senility

Flu Duration 2 wks

Due to 330

Due to 330

Other conditions 330
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. A. Beach M.D. (M. D. or other)

Address Elijah M.O. Date signed 3-9-44

1125

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S. B. BEECHER, M. D.
Special Agent, Bureau of the Census
SALEM, MISSOURI

RECEIVED
District Health Officer No. 5,
District File Number 444271
Date Filed 5-6-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.